



**AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)**

Please complete, sign and return this form to: South Shore Skin Center, Medical Records Department, 1 Scobee Circle, Unit 3, Plymouth, MA 02360 Or submit via fax to 508-746-9265. Contact us at 508-747-0711 ext. 116 with questions.

Patient Name: Last First MI Address: Street (include Apt #, if applicable) City State Zip Code Birth Date Home Phone #: Cell phone #

I hereby authorize South Shore Skin Center to release my protected health information to:

- Mail to Fax to Hold for pick up by

Name:

Address:

Fax phone number: Office phone number (if known):

PURPOSE OF DISCLOSURE (Please check one)

- Myself Inspection Changing physicians Consultation School Legal Other (specify)

INFORMATION TO BE RELEASED (Please be specific and enter date of service if known):

- Entire medical record, excluding Medical Record Abstract (e.g. H&P, Operative Rpt, labs, x-rays, pathology) Clinic notes Pathology Reports Operative Reports Photographs Medication Records Itemized Bill Other (specify content)

I request the release of the specifically protected or privileged categories of information that I have initialed below:

- HIV test results (PATIENT AUTHORIZATION REQUIRED FOR EACH RELEASE REQUEST.) Alcohol & Drug Abuse Records Protected by Federal Confidentiality Rules 42 CFR Part 2 (FEDERAL RULES PROHIBIT ANY FURTHER DISCLOSURE OF THIS INFORMATION UNLESS FURTHER DISCLOSURE IS EXPRESSLY PERMITTED OR WRITTEN AUTHORIZATION OF THE PERSON TO WHOM IT PERTAINS OR AS OTHERWISE PERMITTED BY 42 CFR PART 2). Psychiatric Records or Information Sexually Transmitted Diseases (STDS)

I understand that I have the right to withdraw my authorization at any time except to the extent that action has been taken on reliance on this authorization. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Practice Administrator. I understand that authorizing the disclosure of this health information is voluntary, I can refuse to sign, and South Shore Skin Center will not condition my treatment, payment, health plan enrollment, or eligibility for benefits on my providing authorization for the requested use or disclosure. I understand that health information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient. I understand that if the person or entity receiving Authorized Information is not a health plan or health care provider covered by federal privacy regulations, the authorized information may be redisclosed by the recipient and may no longer be protected by federal or state law. I understand that I may inspect or copy the information to be disclosed, for a reasonable charge.

If I fail to specify an expiration date or event, and unless otherwise revoked, this authorization will expire six months from the date of the signature listed below. I have carefully read and understand the above, have had any questions explained to my satisfaction, and do herein expressly and voluntarily authorize disclosure of the above information about, or medical records of my condition to those persons or agencies listed above.

Signature of Patient (18 years or older) Date

Signature of Legal Representative Relationship to Patient: Date

This authorization expires as of:

Please make a copy of this release for your records.